DATE: _____

TARPON ORTHOPEDICS
Sports Medicine, Spine & Pain Specialists

PATIENT INFORMATION

Name		DOB		
Address				
	Street	City	State	Zip
SSN				
Contact Numbers				
	Cell	Home	Work	Other
OK to Leave Msg?	Circle to indicate **yes** for:	Cell	Home	Work	Other
E-Mail				
Marital Status *(Circle)*	Single	Married	Divorced	Other
Emergency Contact				
Emergency Contact #				

RESPONSIBLE PARTY INFORMATION

Name		DOB		
Relationship to Patient *(Circle)*	Spouse	Parent	Other	
SSN				
Contact Numbers				
	Cell	Home	Work	Other

INSURANCE INFORMATION

Primary Insurance

Please Circle	Group (Employer)	Individual	Worker's Compensation*	Auto Accident	Other
Insurance Name					
Policy Holder Name					
Policy Number		Group Number			
Relationship to Policy Holder *(Circle)*	Self	Spouse	Child	Other	

Secondary Insurance

Insurance Name				
Policy Holder Name				
Policy Number		Group Number		
Relationship to Policy Holder *(Circle)*	Self	Spouse	Child	Other

***Workers Compensation** *If Worker's Compensation injury, please provide the following information*

Employer	
Employer Address	
Employer Phone	
Adjustor Name	

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CONSENT FOR CARE AND TREATMENT

I, _____ (patient name) hereby agree and give my consent for **Tarpon, PLLC** to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical condition.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Tarpon, PLLC and/ or all of its affiliates understand that the medical information about you and your health is personal, and we are committed to protect this information. We create a record of the care and services you receive at our facilities in order to provide quality care and to comply with legal requirements. We comply with HIPAA policy which describes the disclosure and access of your health information. A copy of our Privacy Notice will be provided to you upon request. By signing below you acknowledge you have either obtained a copy of our Privacy Notice, received satisfactory clarification of particular conditions, or choose to obtain a copy at a later date.

RELEASE OF MEDICAL INFORMATION AUTHORIZATION:

I give **Tarpon, PLLC** authorization for the release of "Medical Records/Privacy Information", which includes your PHI, any medical conditions and/or billing and financial information to the following:

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

CANCELLATION & NO SHOW POLICY

It is the policy of **TARPON, PLLC** to bill a cancellation fee to a patient that does not show or cancel at least 24 hours in advance of a procedure, EMG, surgery or appointment. This is to ensure that our treatment team is using their time to diagnose and treat patients that are in need of our services. A patient that arrives 20 minutes past the time of the appointment will be considered a "no show" for the purposes of this policy. Fees for no show appointments will be as follows:

Procedure $100.00 EMG $100.00 Surgery $100.00 Office Appt. $50.00

FMLA/PAPERWORK POLICY

Any FMLA, disability, or other paperwork requiring physician review and completion is subject to a minimum of $25 fee per form.

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MEDICATION REFILL POLICY

In order to provide excellent quality care, Tarpon PLLC adheres to a strict prescription refill policy. Medication refills are best addressed at the time of your visit with our physician, allowing you to update our physicians on any changes in your medication regimen or advise of any new or ongoing symptoms.

- Lost, misplaced, or stolen prescriptions **will not** be replaced.
- Refilling of controlled substances will require an office appointment.
- Refills will only be addressed during regular office hours Monday - Thursday. Refill requests made Friday after 12 PM **will not be processed until the following Monday.**
- Approval of a refill may take up to 3 business days. I understand that it is my responsibility to contact the clinic in a timely manner.
- It is my responsibility to follow the medication in the dosage as prescribed. Early refill requests will not be approved.
- It is my responsibility to maintain my scheduled appointments with my provider. Repeated no shows and cancellations will result in a denial of refills.
- Early refills due to extenuating circumstances will be processed at the physician's discretion.

FINANCIAL POLICY STATEMENT

I agree to assign insurance benefits to **Tarpon, PLLC**. We bill insurance companies as a courtesy for our patients and make every effort to inform patients of network status, however, patients are responsible for confirming with their insurance carrier if they deem our providers as in or out of network. I understand that if my contractual agreement with my insurance provider requires me to pay a copayment, deductible, and/or coinsurance, I must do so at the time of service to receive treatment.

I acknowledge full financial responsibility for services rendered by **Tarpon, PLLC** and authorize transfer of all unpaid amounts to me, which includes, but is not limited to, Co-pays, Deductibles, Co-Insurance, Pre-existing Clauses, excluded conditions and/or termination of coverage. I agree to pay all legal fees including attorney and court fees as well as collection costs in the event of default payment of charges that are my financial responsibility. I further authorize and request all insurance payments be made directly to **Tarpon, PLLC** and authorize said assignee to release all information necessary, including medical records, to secure payment.

I understand that my attending physician(s) have disclosed to me, at the time of initial contact and at the time of referral (i) his or her affiliation with ancillary healthcare provider(s) to whom I, the patient, may be referred, and (ii) that he/she will receive, directly or indirectly, remuneration for the referral to such provider. I understand that I, the patient, have the right to choose the providers of my healthcare services and/or products and, as such, I have the option of receiving ancillary healthcare services from any ancillary healthcare provider and/or facility that I choose.

Please sign below indicating you have read and understand all policies above.

Patient Signature **Date**

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PATIENT RESPONSIBILITY AGREEMENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS

Controlled substance medications can be useful but have a high potential for misuse and are closely controlled by local, state, and federal governments. They are intended to relieve pain, thus improving function and/or ability to work. If Tarpon prescribes controlled substance medications to help manage pain, I agree to the following conditions:

1. I understand that if I refuse the recommendation of my doctor to seek the council of a high risk pain medication specialist when deemed necessary during my treatment, my medication may be discontinued.
2. **I agree to comply with random urine, blood, or other testing to document the proper compliance and use of medication.** I understand that I am responsible for all costs related to these screenings.
3. I understand that driving a motor vehicle may not be allowed while taking controlled substance medications and that it is **my responsibility to comply with the laws of the state**.
4. I understand that the long-term advantages and disadvantages of chronic opioid use have yet to be scientifically determined, and my treatment may change at any time. I understand, accept, and agree that there may be known (physical and psychological dependence) and unknown risks associated with the long-term use of controlled substances. I understand that my physician will advise me of any advances in this field and will make treatment changes as needed.
5. Our practice utilizes Electronic Medical Records (EMR) and electronically prescribes medications when possible in order to minimize delays at the pharmacy, provide low-cost formulary options, and to reduce the chance of medication error. In order for us to provide this service, we must have your permission to have the pharmacy clearinghouse communicate your current medications with our office.

____ Yes, my physicians at **Tarpon, PLLC** may crosscheck for interactions and may have access to my medication profile.

____ No, my physicians at **Tarpon, PLLC** may not electronically crosscheck for interactions and have access to my medication profile.

I understand that if I violate any of the above conditions, my prescription for controlled substance medications may be terminated immediately. If the violation involves obtaining controlled substance medications from another individual, or the concomitant use of non-prescribed illicit drugs, I may be reported to all my physicians, medical facilities and appropriate authorities.

I have read this contract and the same has been explained to me by my physician. I fully understand the consequences of violating this agreement.

_____

Patient Signature **Date**

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MEDICAL HISTORY

Pain/Concern Location											
How long have you had your pain/concern?											
Pain related to injury or MVA?	_____Yes _____No Date of Injury?										
Rate your pain *(Circle):*	*No Pain*	1	2	3	4	5	6	7	8	9	10 *Severe Pain*
Previous imaging or treatments for THIS problem, including previous doctor's name											
Allergies/Intolerances:											

Social History:	Have you ever smoked?	Yes	No	Packs/Day	
		If quit, when?			
	Drink alcohol?	Yes	No	Drinks/Week	
	Use recreational drugs?	Yes	No	Drugs Used	

MEDICATION LIST

Please list all medications you are currently taking and dose

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

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MEDICAL HISTORY (Continued)

SURGICAL HISTORY	
❑	❑
❑	❑
❑	❑
❑	❑
❑	❑

FAMILY MEDICAL HISTORY

Please check all conditions that occur in your family:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Chills
- ❑ Fatigue/Weakness
- ❑ Malaise
- ❑ Poor weight gain
- ❑ Weight Loss
- ❑ Night sweats

EYES
- ❑ Vision loss
- ❑ Visual Disturbance

EAR/NOSE/THROAT
- ❑ Difficulty swallowing
- ❑ Sinus pressure/pain
- ❑ Tinnitus

CARDIOVASCULAR
- ❑ Chest pains
- ❑ Palpitations
- ❑ Other cardiac problems

RESPIRATORY
- ❑ Asthma
- ❑ Shortness of breath
- ❑ Other respiratory problems

GASTROINTESTINAL
- ❑ Change in bowel habits
- ❑ Reflux
- ❑ Other gastrointestinal problems
- ❑ Vomiting

GENITOURINARY
- ❑ Incontinence
- ❑ Other genitourinary problems

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

SKIN
- ❑ Itching
- ❑ Lesions
- ❑ Rash/Redness
- ❑ Other skin problems

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Numbness or tingling

PSYCHIATRIC
- ❑ Anxiety
- ❑ Depression
- ❑ Suicidal ideation
- ❑ Other psychiatric conditions

ENDOCRINE
- ❑ Fatigue
- ❑ Unusual weight gain
- ❑ Other endocrine problems

HEMATOLOGIC
- ❑ Abnormal bruising
- ❑ Bleeding
- ❑ Other hematologic problems

ALLERGIC/IMMUNOLOGIC
- ❑ Allergic rash
- ❑ Sinus complaints
- ❑ Other allergy complaints

OTHER PROBLEMS: